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ABSTRACT

Issues discussed in this conference report include: (1) desegregation as a mental health issue; (2) the responsibility of community mental health centers (CMHCs) for improving the quality of people's lives; (3) community role in crisis intervention; (4) the political responsibilities of CMHCs; (5) the role of the Solomon Carter Fuller CMHC in busing and the Boston school crisis; (6) community needs and CMHC intervention; (7) the legal state of school desegregation; (8) the history of civil rights and school desegregation; (9) the history of CMHCs; (10) the effect of racism, professionalism, and elitism on the mental health delivery system; (11) models of intervention of CMHCs in crisis situations; (12) the relationship of school departments to CMHCs; (13) the role of new careerists, paraprofessionals, and community mental health workers in school desegregation and crisis intervention; (14) the role of media in school desegregation; and (15) perspectives for the future of CMHCs. (WI)

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A Report on the Conference

SCHOOL DESEGREGATION: THE ROLE OF THE COMMUNITY MENTAL HEALTH CENTER

November 7, 1976 through November 10, 1976

Boston, Massachusetts

sponsored by:

Boston University Division of Psychiatry
Solomon Carter Fuller Mental Health Center
Crisis Intervention Program
and
New Careers Program

Submitted by:
Mrs. Ruth M. Batson
Ms. Lyda S. Peters

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
NATIONAL INSTITUTE OF EDUCATION

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A Report on the Conference

"School Desegregation: The Role of the Community Mental Health Center"

This report is a summary of the major proceedings of a National Conference dealing with school desegregation and the types of needed interventions from Community Mental Health Centers (CMHCs). It was held in Boston, Massachusetts from November 7th through November 10th, 1976. Planned and conducted under the leadership of Mrs. Ruth M. Batson, Associate Professor of Psychiatry, Boston University School of Medicine Division of Psychiatry and Director of the Crisis Intervention Program assisted by Ms. Lyda S. Peters, Assistant Professor of Psychiatry and Director of the New Careers Program and staff members of the Solomon Carter Fuller Mental Health Center, the conference was attended by over one hundred people representing a diverse cross-section of those involved in or affected by the topic: administrators and practitioners in CMHCs both in Massachusetts and other states across the country, school system superintendents, staffs of Community Service agencies both locally and nationally, as well as students, educators, Mental Health personnel, and parents who have experienced school desegregation in the City of Boston. Participants came from Texas, Michigan, Delaware, Maryland, New Jersey, Tennessee, Pennsylvania, Ohio, Indiana, and Massachusetts. They included representatives from: Parents Union for Public Schools in Philadelphia; Wilmington Public Schools; Baltimore Public Schools; Austin-Travis County Mental Health Center in Texas; New Jersey Medical School Community Mental Health Center; West Side Community Mental Health Center in Cleveland, Ohio; Rosemary Hill Community Mental Health Center, Maryland; West Philadelphia Community Mental Health Consortium; Human Relations Consortium in Indianapolis; Philadelphia Commission on Human Relations; University of

Delaware Desegregation Training Institute; National Conference of Christians and Jews; Coalition for Peaceful Intergration in Detroit; The National Institute of Mental Health; Boston City Hospital; Youth Employment Program in Cambridge, Massachusetts; Solomon Carter Fuller Mental Health Center; Brookside Family Life Center in Jamaica Plain, Massachusetts; The Hayden School for Boys in Dorchester, Massachusetts; Goddard College, Cambridge; Boston School Department; U. S. Department of Justice; Massachusetts Department of Mental Health; Boston University; Massachusetts Department of Education; Boston State Hospital; Boston City-Wide Educational Coalition; Freedom House Institute on Education in Dorchester, Massachusetts; Education Collaborative for Greater Boston; Cass Branch Y.W.C.A. in Boston; A.B.C.D., Inc. in Boston. The conference was sponsored by Boston University Division of Psychiatry and the Solomon Carter Fuller Mental Health Center.

These people, along with the invited guests, spent three days in intense discussion of both the specific role of CMHCs as well as the multifarious ramifications of school desegregation. The Conference was not designed as a series of formal reports on the 'state of the art'. Rather, it was intentionally planned as a working conference, one in which as many questions would be raised as answered. Thus, it was intended as the beginning of a process of communication among the growing number of professionals who, either by choice or from necessity, are becoming involved in school desegregation as one form of <u>community</u> crisis intervention. Despite the mandates under which CMHCs were founded and despite the increasing national concern with the impacts of such contested community events as school desegregation, community crisis intervention is almost a new field within community mental health.

Where such community crisis intervention has taken place, it is usually as a form of 'consultation' or as an extension of individual/family crisis intervention on to an out-reach basis. Neither type acknowledges that there are events, problems, and conditions which affect an entire community, thereby creating mental health needs, needs which CMHCs are uniquely situated to address, either as prevention or as treatment.

The crisis which may attend the implementation of a school desegregation order represents only one type of community crisis. However, it is the kind of crisis which is complex, emotional, and, because it affects school children, highly visible (with this visibility ranging from the local parade of buses to the mixture of faces in the classroom to the most volatile events finding their way to the national television news). Because the coming of school desegregation has often served to polarize a community, many community institutions - not the least of which are the CMHCs - have sought to avoid all identification with either side of the problem. At the same time the problems surrounding desegregation are often so blatant and so public that institutions are themselves caught up in it. Boston, which has been the scene of the most publicized and editorialized school desegregation process in recent years, has, concomitantly, been the scene of several innovative attempts to meliorate the negative impacts of the crisis - at home, in school, and on the streets.

This conference was, in effect, an outcome of one of these programs. The apparent necessity for a programmatic response to the school desegregation crisis in Boston led to the development and implementation of a Crisis Intervention Training Program at Boston University Division of Psychiatry.

This program trained professionals and paraprofessionals from the Solomon Carter Fuller Mental Health Center and from local community agencies to serve as members of Crisis Intervention Teams which would be located on a contingency basis in schools, police stations, and street corners. The existence of this need and the success of Boston University's response to that need suggested that a National Conference might be an appropriate vehicle for locating comparable national needs and national responses. In other words, the Conference would primarily be a form of dissemination, an opportunity for practitioners with varied experience to exchange data, resources, and ideas. It was also a chance to see whether the idea of community crisis intervention, of which school desegregation provides one example, refers to a significant mental health need, and, if so, what strategies must be developed to enable community crisis intervention to become a permanent feature of the CMHC.

No summary is capable of conveying the feel or the texture of three days of events. As noted, the very diverse group of people who did attend the conference were all participants, all encouraged to play an active role in the sequence of events. And all seemed to agree that the major question at the end was: where to go from here? How to translate what everyone recognized as a fundamental mental health need into specific funded programs? And part of the answer to that question requires a continuation of the kind of interchange which took place during the Conference. If the lines of communication remain open and used, it will be possible to build the expressed unity of opinion which is essential if public policies are to be influenced in the direction of community crisis intervention.

For the purposes of developing a record of conference events, we are presenting in condensed and abstract form, the major presentations and discussions of the conference. Following is an outline of the conference, identifications and descriptions of the presentors and a series of briefs and abstracts outlining, according to the format of the conference schedule, each major session. This is not intended to provide an accurate precis of each speaker's full presentation. Rather, they are meant to provide key ideas and an index of references which will permit the reader to 'locate' the session within the double movement of the Conference and the larger world of professional programs and concepts. The sponsors of the Conference may be contacted for more elaborate and comprehensive information on any or all of the Conference sessions.

CONFERENCE FORMAT

Sunday, November 7, 1976 - Greetings
8:00 p.m.

Mr. William Owens, Senator
2nd Suffolk Senatorial District
Commonwealth of Massachusetts

Monday, November 8, 1976 - Welcome Address
9:00 - 10:00 a.m.

Mrs. Ruth M. Batson, Conference Organizer
Associate Professor of Psychiatry
Director, Crisis Intervention Program
Boston University School of Medicine

Dr. Robert Okin, Commissioner
Commonwealth of Massachusetts
Department of Mental Health

Monday, November 8, 1976 - Case Presentations of Needs and Mental Health
10:15 - 11:45 a.m. Intervention

Donald F. Taylor, Superintendent
Solomon Carter Fuller Mental Health Center
Boston, Massachusetts

Carmencita Jones, Chairperson
Quality Integrated Education Committee
Springfield, Massachusetts

Lyda S. Peters, Director
Boston University New Careers Training Program
Coordinator, Crisis Intervention Teams
Boston, Massachusetts

Rodolpho Sanchez, Director
National Coalition of Spanish Speaking
Mental Health Centers
Washington, D.C.

Luncheon - The Legal State of School Desegregation
12:00 - 2:00 p.m.

Introduction:

Mrs. Dolores Goode, Associate Area Director
Solomon Carter Fuller Mental Health Center
Boston, Massachusetts

Address:

Attorney Thomas Atkins, President,
Boston Branch, N.A.A.C.P.

Workshop - The History of Community Mental Health and Its Responsibility
2:15 - 4:00 p.m. For Safety

Mary Jane England, M.D.
Associate Commissioner
Massachusetts Department of Mental Health

Russell Boxley, Ph.D.
Associate Professor of Clinical Psychology
Boston University
Consultant to the Boston Police Department

Monday, November 8, 1976 - The History of Community Mental Health and Its Responsibility For Safety
Workshop cont'd
2:15 - 4:00 p.m.

Charles Titus
Director of Youth Services
Lena Park Community Center
Boston, Massachusetts

Workshop - The History of Civil Rights and School Desegregation

Dolores Goode, Associate Area Director
Solomon Carter Fuller Mental Health Center
Boston, Massachusetts

Dr. Kenneth Haskins, Professor
Harvard University
Graduate School of Education
Cambridge, Massachusetts

Attorney Eric Van Loom
Center for Law and Education
Cambridge, Massachusetts

Frederick B. Roth
Director of Special Programs
United States Commission on Civil Rights

Clinical Seminar
4:00 - 5:00 p.m.

Robert Muellner, M.D.
Director, Childrens Ambulatory Services
Solomon Carter Fuller Mental Health Center
Boston, Massachusetts

Margaret Pegram, M.S.W.
Director of Training
Roxbury Multi-Service Center
Boston, Massachusetts

Keynote Address - Racism, Professionalism, Elitism: Their Effect on the
7:00 - 9:00 P.M. Mental Health Delivery System

Introduction:

Sanford I. Cohen, M.D.
Professor and Chairman
Boston University School of Medicine
Division of Psychiatry
Boston, Massachusetts

Presentor:

Walter Shervington, M.D.
Psychiatrist
San Francisco, California

Tuesday, November 9, 1976 - Community Mental Health Models of Intervention
9:30 - 12:00 P.M.
Workshop I

Guy Seymour, Ph.D.
Director of Psychology
Boston City Hospital

Graem Hansen, M.D.
Massachusetts Mental Health Center

Barbara Burns, M.D.
Bunker Hill Health Center
Charlestown, Massachusetts

Marty Norman, M.D.
Jamaica Plain Outreach Program
Boston, Massachusetts

Stephen Moss
Consultation and Education Program
Solomon Carter Fuller Mental Health Center

Workshop II

Margaret Pegram, M.S.W.
Director of Training
Roxbury Multi-Service Center
Boston, Massachusetts

Emeline Hanmonoff, M.S.W.
Jamaica Plain Outreach Program
Boston, Massachusetts

Tuesday, November 9, 1976 - Community Mental Health Models of Intervention
Workshop II cont'd
9:30 - 12:00 p.m.

Barbara Burke-Tatum
Director
Cass Branch, Y.W.C.A.
Boston, Massachusetts

Lawrence Perry
West-Ros-Park
Community Mental Health Center
Boston, Massachusetts

Paul O'Leary
Bunker Hill Health Center
Charlestown Boys Club
Boston, Massachusetts

Luncheon - A Dialogue Between School Departments and Mental Health Centers
12:30 - 2:00 p.m.

Introduction:

Ms. Frieda Garcia, Director
Consultation and Education Program
Solomon Carter Fuller Mental Health Center
Boston, Massachusetts

Moderator:

Gregory Anrig, Ph.D.
Commissioner
Commonwealth of Massachusetts
Department of Education

School Panelists:

Robert Long, Ph.D.
Deputy Superintendent
Milwaukee Public School System

Charles Leftwich
Associate Superintendent
Boston Public Schools

Benjamin Turner
Superintendent
Harrisburg, Pennsylvania
School District

Luncheon - A Dialogue Between School Departments and Mental Health Centers cont'd

Mental Health Panelists:

Orlando Lightfoot, M.D.
Director of Adult Ambulatory Services
Solomon Carter Fuller Mental Health Center
Boston, Massachusetts

William Malamud, M.D.
Associate Commissioner
Massachusetts Department of Mental Health

Miles Shore, M.D.
Superintendent
Massachusetts Mental Health Center

Workshop I - The Role of New Careerists, Paraprofessionals and Community Mental Health Workers
2:15 - 4:00 P.M.

Yvonne Rushin
Social Service Worker
Hayden-Inn School for Boys
Boston, Massachusetts

Marie Adams
Coordinator of Intake
Childrens Ambulatory Services
Solomon Carter Fuller Mental Health Center
Boston, Massachusetts

Diane Walker
Community Worker
Childrens Ambulatory Serivces
Solomon Carter Fuller Mental Health Center
Boston, Massachusetts

Lorraine Wheaton
Social Service Worker
Center for Exceptional Citizens
Solomon Carter Fuller Mental Health Center
Boston, Massachusetts

Tuesday, November 9, 1976
Workshop II - Audio-Visual: "A Minor Altercation"

Jackie Shearer
Director and Co-producer
Walnut Films, Inc.
Boston, Massachusetts

Terry Signaigo
Editor and Co-producer
Walnut Films, Inc.
Boston, Massachusetts

Workshop III - The Role of the Media in School Desegregation

Gretchen Wortham
General Manager
W.I.L.D. Radio
Boston, Massachusetts

Paul LaCamera
Community Service Director
W.C.V.B. Television
Needham, Massachusetts

Clinical Seminar
4:00 - 5:00 p.m.

Robert Muellner, M.D.
Director, Childrens Ambulatory Services
Solomon Carter Fuller Mental Health Center
Boston, Massachusetts

Margaret Pegram, M.S.W.
Director of Training
Roxbury Multi-Service Center
Boston, Massachusetts

Community Meeting with Parents
7:00 - 10:00 p.m.

Chairperson:

Elizabeth Johnson, Director
Career and Continuing Education Center
Education Collaborative for Greater Boston

Discussant:

Byron Rushing, Director
Museum of Afro American History
Boston, Massachusetts

Community Meeting with Parents cont'd
Tuesday, November 9, 1976
7:00 - 10:00 p.m.

Parents:

Rayleen Craig
Parent Council
Blackstone and Hale Schools
Boston, Massachusetts

Jane Margulis
City-wide Education Coalition
Boston, Massachusetts

Wednesday, November 10, 1976
Closing Session - Where Do We Go From Here?
9:00 - 12:00 p.m.

Ruth M. Batson
Associate Professor of Psychiatry
Director, Crisis Intervention Program
Boston University School of Medicine

Don Shire, Director
National Center for Quality Integrated Education
Washington, D.C.

John Wolfe, Ph.D.
Executive Director
National Council of Community Mental Health Centers
Washington, D.C.

CONFERENCE PROCEEDINGS

Greetings

State Senator William Owens opened the conference and greeted the participants. He discussed his experiences as a parent who had children attending schools in the City of Boston, his feelings regarding desegregation and the effects of the implementation of the order on Black families. He endorsed the work of the Crisis Intervention Teams operating in conjunction with Boston University Division of Psychiatry and the Solomon Carter Fuller Mental Health Center and supported the need to explore methods of intervention on the part of CMHCs in school desegregation.

Welcome Address

The Welcome Address was given by Dr. Robert Okin, Mental Health Commissioner for the Commonwealth of Massachusetts and Mrs. Ruth M. Batson, Conference Organizer. The entire context of the text is as follows:

Dr. Robert Okin

"Separate educational facilities are inherently unequal. Thus proclaimed the Warren Court in the landmark decision of Brown vs. the Board of Education. Nearly a quarter of a century later our nation is still struggling to implement this decision and thereby abolish the inequality among races which has infected every part of our social fabric: our schools, our neighborhoods, our patterns of employment.

It is precisely the intimate relationship between segregation in the school system and segregation in housing and employment which has made the Brown decision both so incredibly significant and so complex to implement. The anguish, violence and fear which has been created in the process of desegregating our schools attests to this.

Unfortunately, the extent of this social upheaval has led some to shrink back from the policies which are necessary to implement the court's decision and ultimately from the court's decision itself. As a society, we cannot afford to turn back in this fashion. The court's mandate was correct whatever the pain produced in its implementation. This nation will have nothing to prode itself on if its people cannot live together, go to school together, and work together without enmity, despite differences in color, culture and economic status. And yet the history of the last 20 years has amply demonstrated that this ideal will not be won easily, will not be attained without struggle and anguish in many of our cities. It is precisely this anguish which makes the process of desegregation a mental health issue. As such CMHCs have an affirmative responsibility and an aggressive role to play in assisting the communities to deal with the process of desegregation. I stress the word affirmative to convey my conviction that CMHCs should not wait to be asked, nor should they wait until the second act of the drama. They must seek to intervene at the outset when they can often have their greatest impact.

Before dealing with the various strategies of intervention, I want to impress upon you my feeling that centers have an affirmative responsibility in this arena.

First, the Community Mental Health Center is founded on the concept of the catchment area, the notion that the center has a responsibility to all the people living in a defined geographic area--not merely those who happen to walk through its doors. This responsibility for an entire population is in many ways the most radical aspect of the CMHC legislation, its most telling innovation; it is the characteristic which most clearly differentiates it from the health care system in general and the traditional antecedent forms of mental health care in particular. Indeed, it is the catchment area principle which differentiates the CMHC from almost all pre-existing social legislation in the United States and has the greatest presumptive implications for our center's affirmative action in the desegregation process.

Secondly, the Community Mental Health Center legislation as elaborated by the National Institute of Mental Health broadened radically the objectives of the traditional mental health system, to include primary and tertiary prevention, not merely treatment of acute disorders.

Intimately related to this was the conviction that the center had a responsibility for improving the quality of peoples' lives not simply helping them solve their intrapsychic conflicts. This emphasis led inevitably to the recognition that the distress endured by people for whom the center was responsible did not merely arise from intrapsychic conflicts but from the interaction of social and economic forces as they affected the individual. No longer could the mental health system view the individual independent from his environment. The CMHC now had a responsibility to actively deal with the social and political environment which was often the source of much of the individual's distress.

The responsibility of the CMHC for a geographic based population, the objective of improving the quality of people's lives, the emphasis on prevention in addition to treatment, a conviction that people cannot be viewed in isolation from their environment, and the necessity of the center to intervene in this environment as the source of both problems and solutions--all of these principles have profound implications for the role of the CMHCs in the desegregation crisis as well as for the particular strategies of intervention in this crisis.

In a sense, the responsibility of the CMHC in dealing with the desegregation crisis is no different in principle than its responsibility in initiating or supporting the struggle against restrictive zoning ordinances which seek to prevent the mentally ill or mentally retarded from living in particular neighborhoods. The center's responsibility in both cases derives from the belief that the individual is affected by his environment, which the center must act upon if it is to truly assist its client and the community. Both involve the center in the struggle for people's civil rights. Both require the center's participation in social action. The center cannot accept its responsibility in the one case and not the other.

The unhappy fact is that until recently, the CMHC in many places in the nation has not fully accepted this responsibility in either case. Let me say that there are clearly centers which represent notable exceptions to this generalization, in the desegregation of our school systems, but in all honesty we must acknowledge that CMHCs in many cities have played no more than a reactive role, have often waited to be invited into the social arena, and have devoted no more than token resources to the effort when they <u>have</u>

ultimately become engaged. What are the reasons for this failure?

1. First, despite the principles on which CMH was founded, many professionals as well as citizen boards have not really internalized these principles. Involvement in social arena therefore has often been seen as an add-on; not the central core of the center's responsibilities. Action has often been eclipsed by pious rhetoric.
2. Secondly, even when the objectives of CMH have been internalized, the process of involvement in the social arena has often stirred up a great deal of anxiety, among professionals who went into the field of mental health to engage in very different kinds of activities many of them being confined to the consultation room. The training of mental health professionals even 20 years after the CMHC legislation was enacted and 24 years after Brown vs. the Board of Education in many places does not adequately equip people for the roles they must play on the firing line in the social arena.
3. Thirdly, some centers are frightened of being viewed as taking a political stand on major social issues even when the latter have a crucial bearing on the quality of life in the community as well as on the narrower issues of the degree of emotional distress of the center's clients. We must examine this more deeply, for it often stands as the greatest obstacle to active involvement in social issues such as desegregation.

The anxiety here is often that taking a stand will so alienate the community as to reduce both the latter's support of the Center and reduce the Center's ability to intervene clinically in the lives of its patients who will be so angry at the Center that they will refuse to seek its assistance even for unrelated problems. In a word, the Center is often afraid that a political stand will reduce its accessibility to community folks who need help with clinical issues. The possibility of being at war with the community with whom the Center is charged to assist, and on which the Center often depends for its financial viability is a frightening spectre. This is even more complex when the CMHC board which allegedly represents the community has strong feelings about the issue at hand which might be in opposition to those of the staff.

4. The crucial question then is not whether CMHCs should be involved in the process of desegregation, but how, in what ways, using what strategies, with what types of personnel; and with what percentage of their resources. A convenient framework might be to think of the issues in terms of strategies of prevention.

   1. In the area of primary prevention, the Center should aggressively seek to participate in planning discussions around the strategies of implementation of the desegregation process. The Center has a major role to play in

assisting Community leaders and courts to see that communities must be prepared for radical social transformations. It can help community leaders devise such preparatory interventions. How to prepare the teachers, principals, community institutions for the desegregation of its schools is a major role which can be played by CMHCs.

2. In the area of secondary prevention, the Center has a major role in helping the community deal with the pain and violence which certain desegregation implementation processes engender both in black people and in white people. The issue here is not only an ethical one, but the fact that people are in pain. Interventions can range from consultation to educators, clergy, town officials and children to riding in busses to help black and white children deal with their fears, negative self-images etc. Other interventions include dealing with the family crises which result from the desegregation process. These interventions must be active not reactive. The Center must be actively not passively available to the community. It must attempt to insure that it will be where the action is, not just back in its offices.
3. The area of tertiary prevention is perhaps the least discussed and most important. It is vital for the

> Center to intervene directly and through consultation and social action to reduce the extent of fear, hatred and isolation between black people and white people after the desegregation process has been fought and won. For winning is not merely achieving desegregation. The ultimate goal of the desegregation process is people living and working together with equal opportunity side by side without fear and enmity. The Center must help community leaders develop strategies to achieve this goal and not allow it to be subverted and made more difficult to achieve by the anger and fear which the desegregation process has created.

Interventions in all of these areas are made immeasurably easier if the Center Board is willing to actively participate in the process. Moreover the extent to which the center is organically connected to the community before the desegregation process begins will have an important influence on its ability to affect the course of this process. If it has not been so connected it will be treated as a foreign body and will likely be extruded. Finally, the use of indigenous workers to deal with the community and its leadership is critical if the center is going to be able to influence community attitudes and behavior.

Before leaving the issue of intervention, it must be noted that intervention strategies will vary, just as they vary in the clinical arena. Strategies will depend on the relationship of the center to the community, the

philosophical position of the board, the extent to which the board and staff are connected to the community, the particular point in the process of desegregation the center enters the arena, and whether or not the center is operating in its own catchment area or that of another center. The attempt to find a cookbook formula is a waste of time and can lead to devastating and fatal mistakes.

In closing, I'd like to reiterate my conviction that this conference should be involved in the desegregation process. Rather, discussion should focus around strategies of intervention. The attempt should be to develop a theoretical framework within which practical modes of action can be developed which take into account the generic as well as the unique aspects of the particular context in which the Center exists. Finally, I'd like to stress how important the subject of this conference is. If we are not able to get our children to live together in peace, what hope is there for the next generation of adults?"

Ruth M. Batson

"I would like to welcome all of you to our conference on the Role of the Community Mental Health Center in School Desegregation. This Conference presents a unique challenge and by your attendance you demonstrate your acceptance of the challenge. I would like to offer you some background on this meeting and where we hope it will lead.

This is the first conference we have organized on this subject and it may be the first anyone has organized with the specific focus on the role of the Community Mental Health Center in School Desegregation. Although school desegregation and all it implies can be viewed as a broad subject, the aims of

of this conference are specific. While we will often be discussing all aspects of school desegregation - the civil rights legislation, the problems of urban schools, racism, etc. - we will always be returning to the specific theme of the role - potential and actual - the role which CMHCs can play in a continuing public crisis such as the one we are experiencing in Boston which in our view is not caused by desegregation but by the reaction of the communities to the implementation order to desegregate schools.

All of you probably have some familiarity with the Boston situation. No other school desegregation case in the past decade has galvanized public opinion like the ongoing crisis here in Boston. A nationwide audience has watched as school buses rolled up the hill to South Boston High School between phalanxes of policemen keeping back a hostile and aggressive crowd. Scenes like this have been repeated over and over to the point where some people may be surprised to learn that most children do attend school every day in Boston just as they do in schools throughout the country. As a northern city and one strongly identified with a liberal, academic image, Boston was easily made the symbol of all that was wrong with school desegregation. Be that as it may, it is not the purpose of this conference to bewail either side of this extremely emotional issue. What we are here to talk about is the reaction and the mental health impact of the implementation of the desegregation order on the children, parents, and others in the growing number of American cities affected by it.

The image of school busses inching their way through a torrent of abuse is a certain kind of instructive distortion. The television theater created by such events is not a daily occurence. However, the effects which one can

expect such an event to have on its participants - the children riding those buses - are daily stresses which that image serves to dramatize, whether we are talking about a child frightened and confused by a new and volatile school, a teacher struggling with new racial dynamics in the classroom, or parents agonizing over whether to send their child to a particular school. In all these instances we are talking about problems with much more than an educational impact. Multiply these many times over and you have a community trying to deal with new demands, new rules, and new realities. Not only does a crisis such as this generate continual threats to the psychological well being of those touched by them, but most often the people who are responsibile for dealing with the immediate expressions of these problems - the people, teachers, school administrators - are unprepared for them, have no training in handling what are essentially the kinds of problems we in the field of mental health are supposed to be accustomed to dealing with. Admittedly, the problems take different forms for which none of us has an immediate solution. But it has been our experience over the past two years of school desegregation in Boston, that mental health professionals and community agencies are faced, in school desegregation with some legitimate mental health problems. Because of our role as care givers and the charge to the Community Mental Health Centers we should be more able than any to confront.

With the support of Boston University and the Solomon Carter Fuller Community Mental Health Center, we have had an opportunity over the past two years to become involved in Boston's school crisis. Given that intervention in a community crisis of this sort is a new domain for us, I believe that our initial explorations in the area of training and the use of Crisis Intervention

Teams have been significantly successful ones. They have sustained our belief that the CMHCs can in fact develop programmatic responses to the very urgent mental health needs created by the implementation order to desegregate the schools - needs that range from the televised conflicts to the daily crises of different students rubbing elbows in a crowded school corridor.

Our success in putting together some model programs encouraged us to organize this conference as a way of sharing concerns and ideas with you. We do not pretend to have answers to the many problems raised by such a complex social issue. We hope that during the course of the next two and a half days, we will hear the kind of discussions which will raise all these questions.

Certainly, there are problems in defining exactly the nature of the impact of the crisis on different populations: there are problems in analyzing the capabilities of CMHCs to make a coherent response: there are problems in developing the proper kind of in-service training programs which will enable a CMHC to translate a policy into an Intervention Program. In other words, what exactly is the problem: Where do we begin to deal with it? Whose responsibility is it? What are the odds of success? What are the risks of failure?

Our experiences in one of the most contentious of all school desegregation cases have led us to believe that there are answers to these questions - that not only can we develop a significant mental health response, but that it is actually our responsibility to do so.

Naturally, we don't expect to see these questions answered during the next two and a half days. We hope that within the structure of our program, some beginning will be made toward that end. However, we also hope that this process will not end here. In talking about a theme such as ours, it is fair to say that even using the phrase "state of the art" is premature. Community Crisis Intervention is a relatively new field with all sorts of potential ramifications. Thus, our goal in calling this conference was simply to begin a process of sharing experiences and ideas with mental health professionals when facing similar crises in cities throughout the country. If we accomplish nothing else, we hope that this discussion will not end here. Rather, our immediate objective will be to establish some forum, some vehicle, some organized way through which we can continue what this conference can only begin."

Case Presentations of Needs and Mental Health Intervention

Rodolpho Sanchez stated that he came in order to represent the Hispanic viewpoint. Having consulted recently with the U.S. Army in Europe, he felt that there and elsewhere, race relations were of paramount concern and will continue to be. One problem, though, is that people see race relations as a black/white phenomenon, when, in reality, there are dozens of groups of of color, including the Hispanic, who comprise 48.5 million people in the U.S. Mr. Sanchez spoke, from his viewpoint, under three headings: school problems, both racial and otherwise of the Hispanic, the mental health consequences of desegregation, and the role/activities which CMHCs might pursue with respect to desegregation and education. Under school concerns of the Hispanic, Mr. Sanchez included (1) voluntary vs. compulsory desegregation,

(2) use and misuse of labeling with minorities, (3) curricula which exclude Hispanic culture, (4) policy making processes which also exclude the Hispanic, (5) the implementation of a desegregation plan, including approvals and timetables, (6) the quality of education after the initial desegregation crisis has passed, (7) vocational education vs. higher education, or the kind of counseling offerred to Hispanic students which often results in a lowering of their self-image and a deflection of their goals towards vocational education, (8) teacher recruitment and training, and (9) program assessment. Some examples of the mental health consequences of desegregation were school anxiety, fear of failure, disruptive behavior, decrease in aspirations, increase in drop-outs, loss of identity, and less impulse towards community development. "People do discriminate , as well as CMHCs, whose behavior, as with all institutions, depends on who controls them." Are there any among the 500 CMHCs in the country which are truly controlled by minorities, even when minorities are the majority of their catchment area? CMHCs can do things, including (1) a more active political stance based on mental health consideration, (2) increase in out-reach services, (3) assisting communities towards fostering a positive community image, which means helping them to acquire 'political clout', (4) develop out-reach centers which are staffed with people who are bi-lingual and include staff who are paraprofessional residents in the catchment area.

Ms. Carmencita Jones, Chairperson of Quality Integrated Education Committee of Springfield, Massachusetts, offered a case history of the peaceful integration of a school system which had undergone nine years of contentious litigation around school desegregation. Her purpose was to point out that it can work, both in whole cities, like Springfield, but also in those many neglected individual schools in Boston which have also experienced a peaceful

constructive integration, via effective planning. The second purpose was to illustrate the means whereby peaceful implementation can become a reality, using the QIEC experience in Springfield as a model. QIEC was a parents'/ citizens' group which first sought to intervene before the courts in 1973. This early effort, which made QIEC privy to court data and events, was crucial to further success. The process employed by QIEC was, in essence, a concerted monitoring and lobbying effort built around QIEC's broad-based community constituency. The official, school system plan was opposed after being fully analyzed. A surrogate plan was developed and introduced to the court. But, most importantly, a coherent effort at community education was undertaken in two parts: (1) a research team studied all aspects of the school system, from custodians' salaries and duties, up through the budget, brought together supplementary data from such places as the welfare department, complemented it with national comparisons, and then broke the information down into useable units, what amounted to ammunition for the second part of this campaign, (2) contact teams which flooded the city with speeches before various civic, business, and community groups, all carrying the message that (a) the city needed the plan, (b) the schools needed over-all improvement, and (c) implementation must be peaceful but would only be peaceful through their leadership. Forty-two groups were visited in this way and the community education program culminated in a "Peaceful Integration Day" about three weeks before the schools finally opened desegregated. This was a specific case study of intervention in a school desegregation crisis on a community-wide basis. However, it was not an intervention of a CMHC, but of a genuinely community oriented coalition group. Still, it can serve as a model for CMHCs and others, both as a process and in terms of specific successful techniques.

Ms. Lyda Peters described another example of effective intervention in a school desegregation crisis. The city in point was Boston, and the case she described was the Community Crisis Intervention Program at Boston University, a vanguard program born amid the chaos of the first year of desegregation and then formalized and funded by NIMH for the second and third years of school desegregation. Ms. Peters described the background to the Boston crisis including (1) lack of preparation on the part of all involved people, from teachers to policemen to bus drivers, (2) poor planning and coordination on all levels, and (3) lack of expectation of and preparation for the mental health effects of the crisis, ranging from the quiet sort of micro aggression contained in a word or a nudge up to the macro aggression which took the overt forms of beatings and stonings. The case was followed from the voluntary, individual efforts of Year I, through the training program developed prior to Year II, through the success and frustration of Year II. During Year II the Intervention Teams, trained and coordinated by BU Division of Psychiatry and made up of volunteers largely from the Fuller CMHC and its associated agencies, were in place at a number of high schools and other troubled spots in the city. Other program aspects included evaluation, contacts with relevant agencies, dissemination of information on the Crisis Teams on local radio, etc. Outcomes have included a Training Manual published recently and describing in detail the model Crisis Intervention Training undertaken at BU. Another outcome has been a series of meetings with representatives of other CMHCs with the goals of both concerted action and replication of the training program (so that, in effect, the training becomes the training of trainers: people who can return to their department or agency and pass on significant aspects of the training to their fellow staff people.) The Boston School Desegregation Crisis, though continuously traumatic,

provided a logical chance to test the practicality and desirability of community crisis intervention through this program.

Working Luncheon: The Legal State of School Desegregation

Mrs. Goode introduced Mr. Atkins, who is presently working on the National Legal Staff on cases dealing with school desegregation, with a short summary of some relevant items in the history of segregation in the city of Boston. The summary establishes that the history of Black efforts to attain quality, integrated education is a very long, persevering, and frustrating one. Mr. Atkins also offered up some history vis-a-vis Boston, by pointing out that Boston was (a) the first city with a law requiring segregated schools and (b) the first city with a law requiring desegregated schools. Mr. Atkins traced a similarly contradictory dichotomy through two areas: a history of the legal decisions leading up to the one in Boston, and a description of the breakdown of institutional leadership which precipitated the crisis in Boston, following the court order. The history of legal decisions can be summarized, in its modern era, through six dates: (1) 1896, when the Supreme Court, in Plessy vs. Ferguson, expounded the 'separate but equal' doctrine, a landmark decision which not only made the courts the legal battleground for desegregation but also provided the legal rationale for all subsequent Jim Crow type public action; (2) 1952 when, after a series of cases involving separate Black state law schools, the Supreme Court decided that a truly separate, physically equal, Black law school was inherently deficient, (3) 1954, when, in the famous Brown Decision, the Supreme Court officially struck down the Plessy verdict, stating that separate was inherently unequal; (4) 1971, when, in

Swann vs. Mecklenberg, the extensive powers of Federal District Courts to prescribe remedies for proven segregation were upheld by the Supreme Court; (5) also 1971, when in Keyes vs. Denver, the Supreme Court declared, vis-a-vis schools which do not have a history of explicit statutory segregation, that deliberate actions on the part of public officials were tantamount to such laws and were equally liable to court suit; (6) 1974, when Judge Arthur Garrity culminated years of political, social, educational, and legal battles by finding for the plaintiffs against the School Committee of the City of Boston. Mr. Atkins also described in detail the standards which plaintiffs must meet if the courts are to agree with them in their appeals. For example, one must not only show that there was segregation, one must also prove that it was the result of direct, predictable, and avoidable actions on the part of school officials. These are rigorous standards of which most people are unaware. The second half of Mr. Atkins' talk, which dealt with institutional collapse and the problems of implementing desegregation in Boston, described some of the unique features of Judge Garrity's order (e.g., the matching of universities with specific schools), the traditionally poor quality of the Boston schools, the explicit attempt of many leaders in Boston to avoid compliance with the law, particularly public officials, and , in the end, the relative rarity of violence in Boston schools, where over 95% were desegregated without problems. Mr. Atkins' talk was a well-argued and spirited defense of the value and necessity of court-ordered desegregation.

Workshop: The History of Civil Rights and School Desegregation

Mr. Roth, of the U.S. Civil Rights Commission, initiated the discussion with a presentation of the methodology and conclusions of the controversial

Report by the Commission, titled "Fulfilling the Letter and the Spirit of the Law: Desegregating the Nation's Schools." He prefaced this discussion with some comments on areas in which he felt CMHCs might play a significant role in a school desegregation situation. These areas were four and all related to the larger topic of adequate preparation--helping school administrators, teachers, the pupils, and parents to understand what was taking place, why, and how to adjust to it. The Report itself has generated some confusion, especially with regard to the data which supported its conclusion. These conclusions were based equally on a series of activities which took place over a nine month period: (1) an in-depth study of Prince George's County, Maryland, which was also studied four years ago; (2) a consultation seminar on the problem of white flight, a seminar attended by both proponents and opponents of busing; (3) four public hearings held by the Commission in Boston, Denver, Louisville, and San Francisco; (4) four open meetings held by State Advisory committees in diverse cities across the land; (5) 29 case studies which were purposive in the sense that they included cities with poor success at desegregation as well as those with marked success; and (6) a national survey of 1300 local districts randomly chosen from a list of districts having at least 5% minority students. The major conclusions of the study included (1) leadership is the key to success: leadership in the school system and leadership among local officials; (2) preparation is crucial: effective planning which is more successful the earlier it involves a large number of people; (3) the quality of education does not suffer under desegregation; (4) busing is an artificial issue in a country where over 50% of the students are bused to school but only 3½% are bused for the purposes of desegregation; (5) the children have learned from the cross-cultural, cross-racial experiences; and (6) there is uneven

discipline in the schools, resulting in a disproportionate percentage of blacks being suspended or expelled or dropping-out. In summary, the Commission found that desegregation does and can work, but that there are certain identifiable activities which will help it to either fail or succeed--activities in which there is a role for CMHCs.

Mr. Van Loon, who is currently representing the plaintiffs in the Boston Federal Court, provided a detailed background on the Federal Court decision which led to the present crisis in Boston. This background, specific both to Boston and to the plan which evolved from the court decision, complemented the national legal background offered in Mr. Atkins' talk earlier. After explaining why it was necessary for blacks to resort to the Federal Courts for equity (including examples of the devices utilized by the School Committee to either circumvent desegregation or create segregation), Mr. Van Loon proceeded to outline the structure of the plan, the implementation schedule, the checks and balances built into its modification and monitoring, and the unique range from the City-wide Magnet District, to the pairing of universities and businesses with certain schools, up to the elaborate mechanisms created to permit parent participation in school decision-making on the local level. Mr. Van Loon also pointed out that the evolution of the Federal Plan took place within a confused legal and political situation--one in which the State's own Racial Imbalance Law was repealed--for political reasons--just as the preliminary plan finally mandated by that law was about to be put into effect in Boston. The Federal Plan was not really implemented until the second year and, therefore, has really had only one year, so far, in which to prove itself.

Mr. Haskins talked about many of the questions raised around desegregation but often ignored. For instance, he stressed that desegregation first came up in the context of, not equality, but the quality of the education black parents saw their children receiving. This was as true ten years ago as it was a century ago. Just as the motivation for desegregation was a desire for quality education, there are many subtle problems which develop during desegregation which, though existing prior to it, are exacerbated by it. However, despite the anxieties of parents on behalf of their children, we should not forget that children do develop ways to handle new situations. Mr. Haskins spoke also of the implications of the Court Order--implications often neglected. For instance, the court victory enabled Blacks to feel that they had an impact on this system supposedly designed to serve them, while, simultaneously, it meant that whites had to give up just a little of what they had. This was positive. Mr. Haskins also spoke to some of the problems which are subsequent to desegregation. One example has to do with the present status of the teaching profession which judges itself not, as in the case of other professions, on surmounting particularly difficult tasks but on smoothing the way for itself--in other words, good teachers are the ones who have good pupils and not the ones who have the greatest teaching accomplishment (if they do, they get transferred). In this professional self-definition, black children are seen as the ones in the need of most help, therefore they are the ones given the least. Another area, post-desegregation, which demands attention and effort includes some superficially trivial episodes which, however, small, have the potential for turning into major conflicts. The inclusion of a black on the cheerleading squad and multi-racial 'kissing' scenes in school plays were instances described by Mr. Haskins.

Workshop: The History of Community Mental Health and Its Responsibility for Safety

Dr. England opened the panel with introductory remarks. She stated that CMHC's had been uncomfortable with the activist role. Some workers had designed non-traditional programs. These programs had moved the Centers closer to the intention of the CMHC legislation, but for the most part the professionals had difficulty identifying activism and unfortunately remained trapped in their buildings.

When the Desegregation Order was issued, the Mental Health Centers felt that their presence and availability were sufficient. Therefore, no planning took place to cope with the particularly difficult issues of safety that emerged. Dr. England then outlined the panel's role as follows: She said that experience in school desegregation had shown that as difficult as the first two years are, the years after were even more difficult. By that time the students filled the vacuum left by the adults and organized internally. Many times this led to serious discussions and problems. How can the issue of safety and desegregation be addressed--what is being done, how can we build on what we have learned?

Charles Titus discussed the role of the police and how this role affected the students--how students perceived the police. He said that schools had taken on the look of jails with armed guards, patrols between classes, and corridor sweeps. Teachers had in too many instances turned discipline over to the police and the police responded often as if they were in the street--rough and harsh. Many students perceived police treatment of them to be unfair and influenced by racism. White students are known to white police officers because they come from the same communities. When black students demanded more minority police officers, the response would be only temporary. There would be black officers on the scene for approximately two weeks and the situation would revert to its previous status until the charge was made again. Titus stated that the police are also frustrated because they are working in an unfamiliar situation under

unexpected circumstances. The students have a negative image of the police which Titus believes is enforced by the media. Titus also feels that as students view the police, they do not see role models. Students from single parent families and students who have been through the juvenile justice system were especially hostile to the police in his opinion. Titus reminded the audience that he was speaking from a black perspective, since as a black worker his contact was with black students. He said, however, that his talks with white workers revealed similar complaints about the police. Therefore, the police were placed in the middle of the controversy.

Dr. Boxley's remarks dealt mainly with his activities as a consultant to the Boston Police Department. He said that less than three percent of the Boston Police Department were from any minority groups. In the last three years Boxley stated that eighty recruits, Hispanic and Black, had been added to the force. This represented the largest number of minority officers ever enrolled. There are now one hundred and thirty minority officers, two superintendents, one sargeant--all the others are detectives or patrolmen. In Boxley's opinion this does not represent much power. The average age of the Boston Police officer is fifty years. The speaker commented on the power of the police union. The union has twenty five hundred men. It is very active, militant, conservative, and anti-bussing. In spite of this strong resistance, intervention strategies and training had been designed to deal with the bussing crisis with the bulk of the responsibility for its implementation assigned to the Tactical Patrol Force and the members of the last two recruit classes which contained the large group of minority members. Boxley observed that both police and students were victims of institutions which had abdicated leadership and which did provide guidelines. Police were the first group called upon, the least prepared, and the first blamed. He said he was not an advocate for the police but for competency and for all people doing what was right and assuming their share of responsibility.

The discussion that followed led to the following conclusions:

1) Use of student teams for peer control and youth leadership development have proven to be effective methods in the desegregation implementation.

2) Joint Training sessions with Mental Health groups and the police, the exchange of skills are important ways of breaking down tension between the two groups.

3) There should be recognition of the difficult role that the police are placed in and back up assistance should be maintained or offered.

4) Development of a specially trained desegregation police unit which would project a positive experience and reduce the present emphasis on containment is a recommendation that should be considered seriously.

Clinical Seminar

The clinical seminars allowed conference participants to share some of their experiences with the desegregation issue. The common agreement was that it was a difficult time for everyone--children, parents, students, and school personnel. These sessions were led by Dr. Robert Muellner, a child psychiatrist and Mrs. Margaret Pegram, a clinical social worker who felt that the productivity of this seminar was measured in terms of the mutual sharing and informal discussions which looked at the frustrations, anxieties, as well as the accomplishments of the various participants at the conference. The conclusions reached during these seminars were that proper leadership at the state, federal and local levels played a major role in the success of the desegregation order; that depending upon the court order and the monitoring component, desegregation of the nation's public schools would succeed or fail; and that school personnel and mental health professionals need a better communication system in order to give consistent support to children and their families.

Keynote Dinner: Racism, Professionalism, Elitism: Their Effect on the Mental Health Delivery System

Dr. Cohen's introduction of Dr. Shervington stressed how long it had and continues to take for mental health people to acknowledge the need for them to become involved in issues like school desegregation. Dr. Shervington's paper discussed in detail the nature of and impact of racism, professionalism, and elitism on the delivery of mental health services in this country. These effects are felt all the way up from private consultations to the policy making centers of NIMH, especially in an era such as this when national pressures seem to give license to racism and to those who would ignore the needs of minority people. Psychiatry as a profession has been a notable culprit in these respects. As one example, it has been related, pseudo-scientific ideas regarding blacks: (1) that blacks are genetically inferior, that is, born with limited brains, and (2) that the personalities of Blacks tend to be abnormal. Themes such as these serve to sanctify an hierarchical social order. Further examples include the current dissemination of theories regarding genetic traits of blacks and the widespread testing of black children with an eye to spotting socially deviant behavior. Racism, professionalism, and elitism tend to be interconnected. Racism is a part of the social fabric and it is nearly impossible for anyone to avoid its effects. In terms of Psychiatry and the Community Mental Health movement, these -isms immediately went into effect. Although or because the CMHC was designed to provide mental health services to those who could not afford private mental health services and because these services were designed to take place in the community, the profession immediately denigrated community psychiatry, relegating its practice to the younger faculty for whom it might serve as a stepping stone into the profession. At the

same time, the presence of a community psychiatry component within the CMHC served to protect the traditional therapists from any community pressure vis-a-vis their kind of mental health practices. Within NIMH, there were no minorities in policy making positions until NIMH began to decline. Psychiatric training involves little in the way of study on racism or ethnicity. Nor is there much effort to recruit minorities to serve as faculty or staff. The socio-economic background of psychiatrists has much to do with those values which see illness as residing only above the shoulders: a parochial, intellectual fraud which serves the interests only of the practitioners. They do not even recognize that the overly individualistic model to which they cling would, if carried logically to its conclusion, force them to accept anti-social behavior on the part of deprived groups as normal, individualistic attempts to triumph over a hostile world. The distortions and perversions brought into psychiatry and the CMHC by the three isms described here c ld, in part, be rectified by a truly community approach to the operation of the CMHC--an approach in which the community did indeed have input into the policy and services of the center. If professionals want to take a leadership role they must be prepared to function adequately in same. The mental health function should predominate over the particular discipline; that is, a team approach works best but is hindered by elitism and racism and the characteristic denigration built into them. Credentialing is another form of elitism. These three sins have been and will continue to be major demons plaguing and interfering with efforts to provide qualitative mental health services. Their roots are deep in our society and only prolonged vigilance will succeed in eradicating them.

Tuesday, November 9, 1976

Workshop I: Community Mental Health Models of Intervention

Dr. Hansen, of the Mass. Mental Health Center, reported on that CMHC's efforts in response to the school crisis, in the longer term context of its continuing collaboration with the public schools. The Mass MHC catchment area of 200,000 people is extremely mixed socio-economically as well as racially and culturally. In the past, work in the schools or with children has tended to have three characteristics: (1) to be diffused among many agencies and programs, (2) to be limited to individual evaluations and interventions, and (3) to be circumscribed by the level of cooperation afforded by the local school authorities. Dr. Hansen, after making reference to the next presentation as an example of a model program in his catchment area, then described his own experiences in a particular Junior High School. He and others were asked in after a series of racial and other disturbances at the school. While his work was primarily in the area of assessment and referral of individual students, he had the opportunity to watch the school evolve significantly during his tenure: from a school on the brink of chaos to one whose example proves that desegregation can work. Because of the unique nature of their catchment area, this school and many others were affected in only marginal ways by the desegregation order.

Mr. Norman spoke about the Jamaica Plain Outreach Program which is affiliated with the Mass CMHC. The Outreach Program is a storefront, interdisciplinary program which grew from community concerns regarding the nature and availability of mental health services. The staff of this program is entirely community-based and the storefront serves only as a communications point. The program has three main services: (1) to be a facilitator or coord-

inator for services among both a loose network of service providers but especially among a large group of people who need, but are not receiving, mental health services; (2) to consult with local agencies on a variety of problems, ranging from school assessments to efforts to reduce the red tape involved in receiving certain services; and (3) direct provision of services, utilizing in all cases the client's home or the facilities of another local agency. The response of this program to the school desegregation was based upon the Youth Advocacy Board which was a joint attempt by several agencies to do some mutual planning and lobbying on behalf of adolescents. This informal board served as a focal point for preparations for year I of school desegregation around the high school and other problem areas in Jamaica Plain. The activities included working and planning with the police, schools, and city bureaucracy; developing communication guidelines, planning for and training bus monitors and transitional aides; and, finally, coverage by both professionals and paraprofessionals of school in Year I. These were all informal activities as much community-led as they were mental health-led. Because Jamiaca Plain had few problems during desegregation, this program was halted after several weeks. Mr. Norman shares the view of others in Jamaica Plain that the media has not been attuned to the demonstrated successes associated with school desegregation in Boston. He also discussed the need to deal on a long-term basis with the underlying attitudes around racial matters. As such, and on a case-by-case basis, his program continues to confront problems of this nature. As an example, he cited the people who attempt to manipulate mental health services as a way to avoid sending their child to a black-dominated school.

Dr. Burns traced the very special response of her neighborhood health center to the very real stresses occasioned by school desegregation. The health center is in the Charlestown section of Boston, a closed community

which is all white and culturally homogeneous. The people in the neighborhood also share a common poverty. Faced with the very strong feelings activated by the impending desegregation, the center was obliged to come up with an operating philosophy, a set of realistic goals to work towards during the crisis. The two goals settled upon were safety and the continued provision of the Center's services (as both a symbol of continuity and as a recognition that 80% of the Charlestown residents use the Center). Beyond this, there was not a great deal which could be done overtly in such a powder keg situation. The classic models for diagnosis and treatment were followed habitually but unproductively. There was some pressure, centered on the perceived service provided by the Crisis Intervention Teams to the Black students to provide comparable services. One service which did evolve was a result of the somewhat false impression of Charlestown as a very cohesive community which, in fact, it is not. The anger, frustration, feelings of impotence, and lack of leadership characteristic of Charlestown (and other poor communities) would all be directed at this latest threat to the community. Without a place to discuss the problems and a place where every point of view could gain a hearing, it would have been more probable that a small splinter group would have formed and succeeded in carrying out a wild, violent scheme. As it was, the center functioned by default as a forum for discussion and for the making of community decisions vis-a-vis the progressive events of school desegregation. While many of these decisions were not ideal, they were the product of a real community process and, as such, represented a moderate consensus. The other problems of the community exceed the school problem and are too complex to describe under this particular form of intervention.

Mr. Moss described the operations of the Boston University Crisis Intervention Teams in terms of their specific involvements with Charlestown. The initial goal, before the formation of the crisis teams, was to find a way to offer some services or resources to the students who would be bused into Charlestown--the kind of resource which they might very well need to alleviate the stresses of their new situation. A consortium of agencies worked on this problem under the auspices of Consultation & Education at the Fuller Mental Health Center. These agencies supplied staff, most of whom then went through the Crisis Intervention Training program. The summer before Year II was spent in (1) identifying the students from the community who would be attending Charlestown, (2) talking with their parents and other adults in the community, and (3) locating space and materials for a resource or after-school center for the Charlestown students. The resource center, located at the Cass Branch of the YWCA, became (and still is) a significant tool in the continuing intervention efforts. It offers a great variety of services ranging from basketball and tutoring through martial arts courses and educational counselling. At the height of the troubles in Charlestown, when the Black Students decided to boycott school, it was this center which served as a holding place for the students--a place where they could discuss the issue and make constructive decisions instead of roaming the streets. The Crisis Teams themselves functioned very well, both within Charlestown High School and also in the police station. Their members developed positive rapport with the students and the staffs. As such, they were frequently called upon to engage in crisis situations as mediators or as witnesses. The witness function was especially interesting, since, without a third-party witness, all involved students would be punished equally for any disturbance, no matter the cause.

Workshop II:

Mr. O'Leary described the Bunker Hill program mentioned above from a somewhat different perspective, since he has been involved in a joint effort by Bunker Hill and the Charlestown Boys' Club to develop a preventative model for targeting risk children. This model emphasizes therapeutic group work and pulls together the resources of existing agencies in order to provide this group work to children identified by the project. This effort dovetailed into the work of the Center in preparing the community for school desegregation. Tact taken was that a comparable change was coming to the community and the need was to cope with it: to learn to live with it. There were two aspects to this spin-off program: (1) work with large groups--people from the community whose involvement helped the center to become tied into the community's own boundaries: its limits, and (2) small group work in which people were able to express their opinions on a range of community problems. The desegregation was perceived by the Center as a potential for violence. The Center's role was not to facilitate desegregation but to help people cope with the changes--to prevent community polarization and fragmentation. In the end, the work done, informal but built on existing programs and relationships, was effective; however, as a volunteer effort it lacked the systemization necessary to follow through or replicate it.

Ms. Hanmonoff essentially followed Mr. Norman's comments on the Jamaica Plain Outreach Program as summarized above. Her major points above and beyond those made earlier included: (1) that the Outreach Program was and is a small program, (2) the Youth Advocacy Board has been its major accomplishment, (3) the Board serves as a lobbyist and/or catalyst for the use or creation of specific school services, (4) the desegregation response was natural, positive, and effective but the Outreach program played no real role in it, and (5) both

teachers and parents have attempted to use Chapter 766 as a way to divert both problem youths and those who do not fit racial/cultural expectations.

Ms. Burke-Tatum also covered ground parallel to that described earlier when Mr. Moss summarized the specifics of the Crisis Team work in Charlestown and the Cass Branch of the YWCA. Ms. Burke-Tatum, as the Director of the Cass Branch of the YWCA, which traditionally had little direct involvement with either education or mental health, was in the position of delineating the process of changing her institution's attitude towards the problems the new involvement has (and still) creates. The Y's participation was peripheral and informal during the first year of school desegregation but this personal contact led to the second year's participation in the work of the Crisis Teams. Through Mr. Moss and the coalition of South End agencies put together via Mrs. Ruth Batson, the Y was drawn into an effort focusing on the youths from the South End--the Y's community--who were to go to Charlestown in Year II. This involved the loaning of staff, the persuasion of the Y Board, and other mechanics of a new kind of community activity. However, as the year progressed, a common realization that the youths from the South End had no place to go once school was over and the buses had deposited them back in their community, led the Y and the Crisis Teams to develop the after-school resource program noted above by Mr. Moss. Once this took place, there were two complementary needs: (1) to get the students to make use of the building and its programmatic resources and (2) to accustom the people in the building to the students and their new utilization of the building. The latter has been part of a continuing in-service training effort, but it has taken time for staff and other building users to become comfortable enough with the kids to mingle freely with them. On the other hand, the students have had their problems. Combining the

individual students with special problems with those who used the Y as a way to release frustrations, a management difficulty ensued which, in the end, was solved by leaving it in the hands of the students themselves. This peer-policing worked. This year the program continues, although the students' frustration levels are not nearly so high as in the previous two years. The Y effort was not only part of a successful mental health intervention strategy, but it also resulted in providing a new and needed youth resource for South End adolescents.

Working Luncheon: A Dialogue Between School Departments and Mental Health Centers

Ms. Frieda Garcia, Director of the Consultation and Education Program of the Fuller Mental Health Center stated that the purpose of the luncheon was to create a dialogue between school administrators and mental health administrators. Each would present their problems--the schools, the mental health needs and past mental health responses; and the MHCs-their reaction to these needs and the prospects of fulfilling them in the future. The series of discussions was moderated by Dr. Anrig, the Commissioner of Education for the Commonwealth of Massachusetts. The three educational panelists went first and Dr. Anrig stressed that their talks would focus on how they, in desegregation, were assisted by Mental Health agencies and how they would have liked to have been assisted: the reality and the dream.

Dr. Leftwich, representing Boston, indicated that the BU Crisis Teams were his major contact with mental health personnel and agencies during the first two years of school desegregation. This was a positive experience, especially as it demonstrated the potential for Mental Health intervention. But it also shows that Mental Health involvement was limited to this one successful effort. Dr. Leftwich believes that the system is only now coming to the point of being able to take advantage of the resources in the mental health area. The

existing atmosphere in the schools, especially among teachers, is a defensive one. An agency working with teachers should be prepared to exercise the three virtues of patience, commitment, and optimism, if it is to experience any success. Teachers are not aware of either their defensive attitude nor some of its symptons or consequences. One of these symptoms has been the rash of premature, unfair, and precipitous suspensions of students. This is an expression of fear and concern on the part of teachers. Mr. Leftwich stressed his belief, however, that the faculty of the schools has come to the point of beginning to address the basic racism and inequity of the system: it is a point of readiness which will affect the future of the system. Other notations of Mr. Leftwich: (1) parent participation did not exist on a broad scale in Boston until ordered by the court, (2) the school administrators and principals selected under the new community process of the court are quite prepared to change the system, and (3) like the teachers, the media has been unaware of the real impact of their selective coverage of events, with their focus on disruptive/violent events at the expense of important but tranquil events.

Dr. Turner discussed the successful desegregation process undertaken by the Harrisburg Public Schools. This occurred five years ago and some of the credit for it must be given to Boston and the innovative programs visited here in the course of planning for the Harrisburg desegregation. The role played by mental health agencies was largely directed at the planners and administrators and it was an important one, for their participation enabled them to alter the thrust of desegregation away from prevention of violence and towards a more positive appeal. Instead of desegregation, the theme became "reorganizing the schools for educational excellence". This theme caught hold, the mechanical planning worked, the sensitivity sessions (suggested and led by Mental Health people) succeeded, and, today, parents in Harrisburg are demanding door

to door busing. One point stressed by Dr. Turner was that educators know too little about kids and adolescents: a kind of knowledge which MH workers possess in abundance and which educators must have in order to really help the students. He noted that many problems are highlighted by a desegregation process which does not really change them. For instance, fights occur all the time in any urban high school, but only with desegregation do they make the evening news. Dr. Turner ended the presentation with a challenge to MH people to (1) dare to work with school boards, public officials, teachers, et al, (2) help educators to understand the real issues involved in any situation, (3) help institutions to overcome that fear which uses the institution's charter to avoid being effective, (4) help educators and others to understand institutional behavior, (5) help parents learn how not to be ineffective or powerless, and, lastly, to help all of the concerned people to stand up for what is right--to 'gird for battle'.

Dr. Long of Milwaukee described that city's status relative to desegregation. It was in litigation of one kind or another for eleven years and, finally, this year, Phase I of a three-year plan was placed in effect. The Judge ordered that one-third of the schools would have to be desegregated each of the three years. Actually, in Phase I, more than a third of the schools were desegregated. However, this was an entirely voluntary phase. Problems will surely develop as plans are made to bring more schools into the effort. Phase I transportation involved mainly blacks and the major difficulty for the succeeding phases is the movement of whites, some way to equalize the transportation of white and black students on a voluntary basis. At the same time, the Judge has ordered that specialty or magnet schools cannot be opened until this equalization has taken place. Dr. Long noted that there has been no

mental health input into these plans or into remediating some of their effects. However, he believes that there is a legitimate role for MH agencies to play, possibly a crucial role. Above all, mental health people could help parents, teachers, and others to develop those values which are prerequisites to change, values which will enable them to not only endure change but to make the most of it. Not only have mental health agencies not been very involved, the schools have also not taken advantage of the many community groups which have resources and experience which are relevant to the present needs. In short, the schools have succeeded with step one of school desegregation without assistance, but could definitely use it through the more difficult years ahead.

The first of the mental health reactions to the educators' panel was Dr. Malamud, who felt, all things considered, that neither he nor his colleagues could say much in return to the problems and needs of the educators, so forcibly expressed. He does hope for greater mental health/educational cooperation in the future and he does believe that the educational model offers more practical promise for mental health than the older illness model. There were four points he wished to make in response: (1) it is vital to plan for things like school desegregation as much in advance as possible and involving the greatest number of people possible: sudden or unplanned changes lead more readily to panic and other negative consequences; (2) it is equally vital to maintain good communications with four groups--children, parents, administrators, and teachers, all of whom need support; (3) mental health professionals should not enter the schools as consultants (all-knowing and so forth) but should enter more humbly as needing themselves to learn

and to offer such help as is specifically asked for by the schools: this applies with two reservations: (a) the need to 'call the shots as we see them' and (b) the likelihood that mental health people must be ready to use their skills and knowledge in non-traditional ways, which means ways which challenge the present mode and organization of MH services; and (4) to recall, always, that it is a human services problem being dealt with and not solely an educational or mental health problem.

Dr. Lightfoot of the Fuller MHC in Boston expounded on Dr. Malamud's position with a particular emphasis on the way that mental health professionals are either seen by society or the image they project to the society. There are certain responsibilities of the profession, things which should be assumed of it. However, there are two competing views of the profession. One suggests that it is made up of miracle workers and that, because of certain delimited skills related to the mind, mental health professionals have a kind of omnipotence. It is important to try and demythologize the profession and to repeat that, as Dr. Malamud said, the profession has much to learn. It is even the case that an individual from the profession may have more of a contribution to make to a social crisis such as this not on the basis of his/her skills but via his/her personal interests. The second view of the profession is an outgrowth of our culture which is inundated with a fear of the unknown, particularly as it relates, again, to the mind: both its function and those, including all intellectuals, who know how to use it. It is important that this kind of fear also be dispelled. Dr. Lightfoot ended by cautioning that in situations such as community crisis intervention one must not neglect individual needs while treating the symptoms of the 'masses'. Individuals remain at the bottom

of the social structure and must always be helped, just as it is really only individual skills which lie at the basis of mental health delivery structure.

Dr. Shore felt at a disadvantage following people with whom he could only agree. There were two points which he wished to stress. The first is that when two systems come together, as the group has today, it helps if each system makes an effort to see the problem from the point of view of the other. Especially in reference to public and political phenomena, mental health types are liable to be very insecure. Educators can benefit from CMHCs if they are willing to recognize and understand the anxieties which confront the Mental Health system: (a) anxiety over a lack of theoretical and practical knowledge, especially since the mental health profession is actually a mental illness profession, with a body of knowledge built on illness not health and almost no knowledge in the area of social change, and (b) anxiety over any kind of public controversy which threatens the already tenuous relationship between the profession and the community. The second point is that while the public mental health system is rightly expected to come forward first in crises, it should be noted that the resources of many CMHC's are already overtaxed. Thus expectations should agree with reality and the private system should also be tapped.

Workshop: The Role of New Careerists, Paraprofessionals and Community Mental Health Workers

This workshop dealt with the role--actual and potential--of New Careerists, paraprofessionals, and community mental health workers in school desegregation and other kinds of community crisis intervention. The three panelists were all employed at the Fuller MHC in Boston and were all members of Crisis Intervention Teams. Ms. Walker described the setting-up of the Crisis

Team at English High School in Boston. Although everyone was prepared to handle a variety of large-scale, overt forms of crisis, there was, in fact, little of this at English. There was not much apparent tension, but the problems soon emerged in more subtle forms (an example of which might be cafeteria seating patterns, with black students in one area and whites in another). The only white students who interacted with black students were those particularly interested in drugs and other activities--this was the only visible commonality among the students. Other symptoms of trouble included, as always, the fact that black students were being suspended for very trivial causes. On the plus side was the fact that the school's new principal was black and was attuned to these problems. As it developed the Crisis Team became a sort of mediator between students and faculty. What was most clear was the enormous gap between needed mental health services and the present educational situation. Though the original crisis intervention did branch out in several directions, what ought to be said is that the Team merely laid the groundwork for future mental health work in the school. Ms. Wheaton echoed the experiences of Ms. Walker and offered further anecdotal proof of the usefulness of the Crisis Teams and the unique contribution made to the the teams by paraprofessionals and community workers. The tensions which did exist at the school seemed attributable to the media. Since teachers and others were afraid to approach the Team about racial issues, the Team became involved in other issues, where there was also evident need for mental health intervention (e.g., Chapter 766). An attempt was made to run a group for pregnant girls. While the group per se was a success, its ramifications in terms of threats to the staff and to the Team were such that the Team would not return this year, though invited by the school, until negotiations

had taken place defining such things as the role of the Team and the faculty's responsibility to support the Team. It should also be noted that English High School was a generally calm place during desegregation. It became tense as a ricochet effect following a day of troubles at a much more volatile school like South Boston. Ms. Adams worked on a Team stationed at a police house in the Mattapan section of Dorchester. Her discussion of the attitudes and reactions of the policemen indicated that there are concrete difficulties in the way of acceptance, especially on behalf of mental health people. The Team was able to develop a relationship with the black policemen and through them the strains and splits in the station--both as a result of outside and inside pressures--became apparent. Ms. Rushin's summary of the discussion which followed the three presentations was the obvious need for paraprofessionals and community-based people to work in situations like a school desegregation crisis. In many cases, they do all the work, especially the most difficult or threatening aspects of the work, like riding buses into South Boston. It is they who, without recognition and without the credentials which lead to position and power, do the direct work with the students and all of the other 'dirty work' which is really what mental health service delivery is all about.

Workshop: Audio-Visual: "A Minor Altercation"

This workshop was a discussion built around a film called "A Minor Altercation", produced by Walnut Films as a kind of catalyst to the consideration of a range of racial and other issues. The meaning of the discussion is accessible only through seeing the film. The film can be summarized as a polar story in which the events which occur happen at once to a black and a white family. It opens with the two families' daughters fighting in the bathroom and being suspended and it closes with the two girls' mothers accidentally confronting a school administrator simultaneously over the fight. The film focuses on the

sequence of events from the mothers' points of view, from the time they learn of the suspension, through their efforts to glean the truth, their conflict with other family members over it, up to their resolution to go to the school and 'straighten it out'. It is a brief, well-crafted film which intentionally raises more questions than it answers. The film stops after a halting or semi-mute recognition by the mothers that they just might share a plight. The fight itself happens more than it is caused by any identifiable behavior on the part of either girl. The technique of presenting concrete situations in a non-directive manner is an effective one for promoting discussion; thus, in a way, the ensuing discussion was only a proof of the film's achievement of its goals. It was generally agreed that the film could be a good tool for working with parents around their attitudes. Since so many people are afraid to discuss their feelings about racial issues, the film contains other points of departure, other issues which are evident and permit the viewers to move on to safer ground to begin a talk. An example of this is the mutual role of mothers which each of the women is accustomed to but which is clearly as oppressive as it is important. Or the evident elitism displayed by the school to the parents for whom they are only a temporary problem, something to be dealt with at leisure, with no understanding of why they were there, no desire to deal with them as full-fledged adults with equal rights. The film can be adapted to a variety of audiences and uses and succeeds admirably in both setting up a problem and prodding people to discuss the problem.

Workshop: The Role of the Media in School Desegregation

This workshop looked at the role of the various media in covering, promoting, and/or impacting events related to a crisis like school desegregation. Ms. Wortham and Mr. LaCamera discussed both the film mentioned above and some of the efforts made by the media to do several conflicting things:

(1) to inform the public about the facts of the desegregation, (2) to report events connected with the crisis both fully and fairly, and (3) to seek to avoid arousing negative or destructive feelings around the events. As always, the media was and is a subject of strong and thoughtful opinions on all sides. Thus, no summary can possibly convey much idea of this session which, after a short presentation by Mr. LaCamera, became a long, intense and complex discussion of the role, limits, and potential of the media in the country. Some of the points made by Mr. LaCamera included (1) seeing the film as valuable because it dovetails with the stage at which events in the city have hopefully reached--that is, one where it is now time for people to begin an interracial dialogue and to begin taking more of an interest in the schools for educational reasons; (2) local news people were annoyed with the national media for over-playing certain dramatic events at the expense of the main thrust of school desegregation; and (3) the media made a special effort to report positive events which took place under Phase I and II. The discussion moved all the way from structural limitations of video in conveying the 'truth' of anything to charges that the media intentionally ignored certain non-violent but significant events because they were not marketable.

Community Reception:

The Community Reception was an evening's discussion with several parents in the community of the South End, the location of the Fuller MHC. This session had, essentially, two parts: an historical overview of the Black experience in Boston and the evolving clash between Blacks and the Irish; and the group discussion focusing on parental involvement and parental problems with the schools. Mr. Rushing's presentation of the ethnic-cultural history was

was organized around a few illustrative incidents in the past 150 years or so of Boston's history. Several features were noted: (1) that many of the immigrant conflicts were over education, (2) that Blacks have always tended to rate education as an extremely high priority, (3) that, in distinction to the racial and class struggle in the South, the history in Boston is of multi-ethnic struggle, and (4) that Blacks' history of slavery is still longer than their history of political freedom. The Boston history is, again, filled with firsts and with those contradictions pointed out earlier by Mr. Atkins. In 1637, a ship built in Marblehead, the Desire, carted to the West Indies male Indians which the ship exchanged for foodstuffs, luxury items, and black slaves. This was proposed as a kind of paradigm or metaphor of American History. The Indians, swooped up as part of a struggle for property, are exchanged for Blacks, those who have been chosen to labor on that property. Other salient dates in this educational survey include (1) 1790, when, the weight of freedom resulting from the Revolutionary War led to the practical emanicipation of Massachusetts blacks, (2) 1834, when the phrase 'separate but equal' was coined to justify maintaining a separate black system, (3) 1855 when under a wave of abolitionism the state abolished segregated schools. As a footnote to the latter, two results should be pointed out: the desegregation which took place then in Boston was quite peaceful, and, the few Black educators who were employed in the Black 'sub-system' lost their jobs in the process. The saga continues, moving with the Blacks to different sections of the city, shadowing changes in school system rules and governance, and ultimately increasingly linked to the fate of the Irish. The Irish arrived in Boston too poor to go any further. The schools offered not the educational aspirations it long held for blacks but the prospects for fulfilling more immediate ambitions--for jobs,

for security, for control of at least one institution which affected the Irish's lives. Once gained, this control has remained through today, with only Judge Garrity's Order as the sole setback along the way. The Parent Councils, the Racial-Ethnic Councils, the Citywide Coordinating Committee, and the Citywide Educational Coalition were all topics for the ensuing discussion. The ins and outs of these issues are too particular to the Boston scene to make much sense dehydrated and squeezed onto paper. All but the last in that list are creations of the Judge under the desegregation order. Clearly, he values parental awareness and parental participation in all phases of school life. The several forms and layers of parental involvement created by the Judge are all in embryonic stages. The effectiveness of some has been stymied by adroit politics on the part of a principal. The goals of others have been deflected by political in-fighting. Still others are lost in the maze of possible involvements and remain on the sidelines as before. Nevertheless, the consensus is that, with the power of the Court to support them, parents now have various routes of access to the system. These routes do not mean power, but they do mean an opportunity which has not existed in the past. Parents seem to be on the verge of institutionalizing their councils and committees and turning their coherence to good account, whether in planning programs in particular schools or in setting up a group to analyze the school system budget. The parent efforts are positive steps, though fragile ones, easily erased by a precipitous exit of the Court or by a series of clumsy but successful School Committee maneuvers. The key is simply 'parent organization': a political process of mutual support, self-education, and , ultimately, power over the policies which affect their childrens' lives.

Closing Session: Where Do We Go From Here?

Mr. Shire of the National Center for Quality Integrated Education explained his organization and the efforts it has pursued in a number of desegregation cases around the country. The key to their own 'intervention' strategy is the development of a community coalition which includes in its roster business, civic, religious, and other groups. This coalition serves as a form of leadership, telling the community, in effect, that smooth implementation of a court order is an aspect of civic pride. The more day-to-day work of organizing parents, disseminating useful information, etc., is usually performed by one or two of the coalition's members or even by the coalition's staff, if the association has been able to reach a point of generating its own funds. In any event, crucial to this approach is the idea of a broad-based, publicly visible coalition within whose banner much of the real work of desegregation can take place. Dr. Wolfe spoke very candidly, from his unique perspective as Executive Director of the National Council of CMHCs, about many relevant matters: (1) the importance of CMHCs involving themselves in community issues and community crises, (2) the fact that the enabling legislation calls for such preventative efforts, (3) the great barriers, professional and bureaucratic, standing in the way of real change on the part of CMHCs, (4) the fact that, for political reasons, the CMHC legislation has never been either fully implemented or fully funded, (5) services in the CMHCs have been flowing in the direction of the funds, which means that components like C&E have shrunk while in-patient services have grown, (6) community pressures combined with the money shortage have helped to encourage Psychiatry to more and more shy away from the community health movement, (7) there should be

more self-policing of the CMHCs through an organization like Mr. Wolfe's--some way to evaluate and hold accountable the CMHCs (something which it is very difficult for the CMHCs staff to do), and (8) some part of the real changes needed may be forthcoming in the new Congress, or, at least, effective Congressional lobbying never hurt anyone. After a lively discussion, Mrs. Batson sought to formalize some of the common suggestions for action. The Conference was intended to result in at least some tentative arrangements for further action and further communication. Some of the ideas raised included (1) need to discuss and present such problems as institutional racism and community crisis intervention in the professional journals; (2) need to develop advocates for the issues raised at this Conference in Congress; (3) the desirability for mental health people, both on a national and a local level, to engage themselves with a group like Mr. Shire's; (4) the need for more coalitions of all kinds, around desegregation, but also coalitions among the several agencies, governmental and otherwise, working in one city in the same field; and (5) the suggestion that the Conference send President-elect Carter a telegram encouraging him to send his daughter to a local public school in Washington, as a symbol of support for public, integrated education.

Although the Conference ended on the last note (about which there was both agreement and action), there seemed to be no doubt in anyone's mind that an extended meeting such as this could only begin to formulate some of the issues. The problems of school desegregation as seen from the point of view of mental health professionals and the institutions which house them are inextricably linked to fundamental problems within those professions and those institutions. Even thematic Conferences such as this one range widely in their course, touching upon a multiplicity of topics. But it may still be worthwhile

to list some of those items which, even if everyone would not agree on their importance, were frequently mentioned during the three days of the conference: (1) school desegregation does create a host of legitimate mental health problems and these problems are not confined to case-by-case interventions but, in fact, reflect a community-wide trauma needing innovative forms of treatment; (2) the need for school desegregation highlights some of the persistent and destructive problems within the school systems--difficulties ranging from the lack of teacher sensitivity to the feelings of students up to the institutional racism and institutional egocentrism which are major problems in the schools and in other institutions; (3) that in terms of the mental health profession there are a variety of needs--in school desegregation and other crises--which mental health personnel can meet, but doing so will require some major changes within that profession and the way it organizes, evaluates, and regulates itself; (4) there are valid and viable models for intervention which exist both formally (that is, models which involve CMHCs proper) and informally (that is, models which utilize mental health skills and personnel but not through the CMHCs per se); (5) both the schools and the mental health professions appear to be moving towards a recognition of their common problems; (6) two major stumbling blocks for effective mental health intervention in a community crisis are the CMHC's own avoidance of their constituting mandate and the fact that the practitioners who dominate the CMHCs may be relying on a 'mental illness' model which is elitist, anachronistic, and destructive. Large topics such as these do no justice to the richness of the discourse during this conference. Both guests and participants brought an unusually high level of knowledge and articulation to the sessions.

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New Careers Training Program
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Ruth M. Batson, Principal Investigator
Lydia S. Peters, Project Director

January 18, 1977

President James Carter
The White House
1600 Pennsylvania Avenue
Washington, D.C.
20500

Dear Mr. President:

We wish to share with you some information regarding a recent conference held in Boston, Massachusetts, November 7 - 10, 1976 entitled:

"School Desegregation and the Role of the Community Mental Health Center"

which was an outgrowth of a community crisis intervention effort. We are enclosing our training manual and conference program. This conference was jointly sponsored by the Boston University School of Medicine Division of Psychiatry and the Solomon Carter Fuller Mental Health Center. The original idea of such a conference came from Mrs. Ruth M. Batson, Director of the Crisis Intervention Program and Miss Lyda S. Peters, Director of the New Careers Training Program at Boston University School of Medicine. In their direction of the programs, they saw very much the need for better Community Crisis Intervention, particularly in the area of school desegregation.

At the close of the conference, it was voted to send you the following resolution:

> Your leadership in promoting racial harmony can prove to be a necessary catalyst in the desegregation process now proceeding under the law in various parts of the country. In those communities when effective leadership has existed, the desegregation process has been harmonious and constructive.
>
> You are the first President since Theodore Roosevelt to send a child to a public school. This action will demonstrate to communities throughout the country the role of leaders in facilitating the desegregation process and the particularly crucial contribution which the President can make as the National Spokesman.

The Members of this conference wish to express their strong support for quality public education and feel that your action will strengthen the system and its objectives.

Sincerely,

RUTH M. BATSON
Associate Professor of Psychiatry
Organizer of the School Desegregation Conference
Boston University School of Medicine

RMB/iyam

enclosures - 2

Boston University Medical Center

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Ruth M. Batson, Principal Investigator
Lyda S. Peters, Project Director

January 18, 1977

Mrs. Rosalynn Carter
The White House
1600 Pennsylvania Avenue
Washington, D.C.
20500

Dear Mrs. Carter:

It has come to our attention that you will continue to take an active part in planning for programs and services in the area of Community Mental Health. We support you and would like to be actively involved in this planning effort at the National level.

We wish to share with you some information regarding a recent conference held in Boston, Massachusetts, November 7 - 10, 1976 entitled:

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The Boston situation has been well publicized. This conference brought together Educators and Mental Health Personnel and Professionals to try and better coordinate the efforts of the two professions in this particular crisis.

The Mental Health Center of course, is involved in a total effort of giving service to bring about a better quality of life for the constituents in the area.

The conference disclosed the need for:

1. Participation at the National level
2. Establishing advocates in Congress
3. Coalitions of Government agencies
4. Greater pursuit of training funds

The conference included representatives from cities that are about to undergo or have recently undergone desegregation such as Philadelphia, Austin, Dayton, Indianapolis, and Wilmington. Session after session, it was brought to the forefront that Educators and Mental Health Personnel have not collaborated with each other in the desegregation effort. We will forward to you the conference papers as soon as possible.

We have members of our community, parents, Educators, and Mental Health Personnel who would make a commitment to actively work with you in the areas of program, planning and services for Community Mental Health Centers.

We consider the matter of our being involved at the National level an important one. Therefore, we would most appreciate hearing directly from you at your earliest convenience.

Sincerely,

RUTH M. BATSON
Associate Professor of Psychiatry
Organizer of the School Desegregation Conference
Boston University School of Medicine

RMB/iyam

enclosures - 2

cc: Arthur Bindman, Ph.D.
Senator Edward Brooke
Representative Doris Bunte
Sanford Cohen, M.D.
Senator Edward Kennedy
Congressman John Moakley
Leon Nicks, Ph.D.
Commissioner Robert Okin
Speaker of the House, Thomas O'Neill
Donald Shire
Donald Taylor, M.S.S.S.
John Wolfe, Ph.D.
Congressman Andrew Young